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Proposed statement of position : accounting by prepaid health care plans;Accounting by prepaid health care plans; Exposure draft (American Institute of Certified Public Accountants), 1986, Oct. 6

American Institute of Certified Public Accountants. Health Maintenance Organizations Task Force

EXPOSURE DRAFT

PROPOSED STATEMENT OF POSITION

ACCOUNTING BY PREPAID HEALTH CARE PLANS

OCTOBER 6, 1986

Prepared by the Health Maintenance Organizations Task Force,
Accounting Standards Division,
American Institute of Certified Public Accountants

Comments should be received by January 6, 1987, and addressed to
Frank S. Synowiec, Jr., Technical Manager, Federal Government Relations, File G1406
AICPA, 1620 Eye Street, N.W., Washington, D.C. 20006-4063

SUMMARY

This proposed statement of position provides guidance on applying generally accepted accounting principles in accounting for health care costs, contract losses, reinsurance, and acquisition costs of prepaid health care plans. Briefly, the statement recommends the following:

1. Prepaid health care plans should accrue health care costs as services are rendered, including estimates of costs incurred but not yet reported to the plan. When a contract with a sponsoring employer or other group is determined to be terminated, the estimated costs that will be incurred after the contract period, net of any related anticipated revenues, should be accrued. Amounts contingently payable to hospitals, physicians, or other health care providers under risk retention, bonus, or similar programs should be accrued during the contract period based on experience to date.

2. When expected future health care costs and maintenance expenses under a group of existing contracts will probably exceed anticipated future premiums and reinsurance recoveries on those contracts, a loss should be recognized. Contracts should be grouped consistent with the prepaid health care plan's manner of establishing premium rates (for example, by community-rating practices, geographical area, or statutory requirements) to determine if an anticipated loss exists.

3. Reinsurance premiums should be reported as a health care cost. Reinsurance recoveries on other health care costs should be reported as revenue. Amounts recoverable from reinsurers that relate to health care costs should be classified as assets, reduced by appropriate valuation allowances.

4. Acquisition costs of prepaid health care plans should be expensed as incurred.

The provisions of this statement would be effective for periods beginning on or after December 15, 1986.

AICPA

American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, New York 10036 (212) 575-6200

October 6, 1986

Accompanying this letter is an exposure draft of a proposed statement of position entitled Accounting by Prepaid Health Care Plans. It has been prepared by the Health Maintenance Organizations Task Force. A summary of the proposed SOP also accompanies this letter.

The purpose of the exposure draft is to solicit comments from representatives of prepaid health care plans, such as health maintenance organizations, and from insurance companies, health care entities, and other interested parties. Comments or suggestions on any aspect of this exposure draft will be appreciated.

Commentators are especially asked to give their views on the fundamental differences that may distinguish a contract for medical coverage from an insurance contract.

It will be helpful if the responses refer to the specific paragraph numbers and include reasons for any suggestions or comments.

Comments on this exposure draft should be sent to Frank S. Synowiec, Jr., Technical Manager, Federal Government Relations, File G1406, AICPA, 1620 Eye Street, N.W., Washington, D.C. 20006, in time to be received by January 6, 1987.

Written comments on the exposure draft will be available for public inspection at the New York office of the American Institute of Certified Public Accountants after February 6, 1987, for one year.

Comments received by the AICPA will be considered by the FASB when it reviews the final SOP to determine whether to designate as preferable the accounting principles and practices contained in that SOP.

Yours truly,

Walter Schuetze
Chairman
Accounting Standards
Executive Committee

Loren Kramer

Loren B. Kramer
Chairman
Health Maintenance
Organizations Task Force

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Technical Manager
Federal Government Relations

Health Maintenance Organizations Task Force

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Lloyd B. Morgan
J. William Tillett

Frank S. Synowiec, Jr.
Technical Manager
Federal Government Relations

ACCOUNTING BY PREPAID HEALTH CARE PLANS

INTRODUCTION

1. The rapidly rising cost of health care services in recent years has led to an increased interest and acceptance of prepaid health care plans. These plans serve as an alternative system for the delivery and financing of health care services. Many employers must now offer employees a choice between traditional insurance coverage and prepaid medical coverage.

2. As a result of the rapid growth of prepaid health care plans, diverse practices have developed in accounting for health care costs, contract losses (premium deficiencies), reinsurance, and acquisition costs. Current accounting literature does not provide specific guidance in those areas; consequently, this statement has been prepared as a basis for reducing the existing diversity of practices. The appendix describes the operations of health maintenance organizations (HMOs).

SCOPE

3. This statement applies to prepaid health care plans (plans) such as HMOs and associated entities (including individual practice associations, or IPAs, and medical groups) and organizations that have characteristics or arrangements similar to HMOs. Such organizations include, but are not limited to, preferred provider organizations (PPOs), eye plans, and dental plans. This statement applies to plans that issue financial statements in conformity with generally accepted accounting principles, whether they are separate entities or are owned by an insurance company, hospital, or other entity.

DEFINITIONS

4. The following terms are used in this statement.

Acquisition costs. Certain marketing costs that vary with and are primarily related to the acquisition of subscriber contracts.

Associated entity. An IPA, a medical group, or a similar entity that contracts with an HMO or other prepaid health care plan to provide health care services.

Capitation fee. A fixed amount per member that is paid periodically (usually monthly) to a provider as compensation for providing comprehensive health care services for the period. The fee is set by contract between the HMO or other prepaid health care plan and the provider. These contracts are generally with a medical group or an IPA, but may also be with hospitals and other providers. The capitation fee is actuarially determined on the basis of expected costs to be incurred.

Copayment. A payment required to be made by a member to a provider when health care services are rendered. Examples of typical copayments include fixed charges for each physician office or home visit, prescriptions, or certain elective hospital procedures.

Date of initial service. The date as of which a health care provider identifies that a member has an illness or shows symptoms requiring the member to obtain future health care services.

Guaranteed renewal contract. A contract that provides the enrolled member with the right to continue coverage as long as premiums are paid, with the right reserved by the HMO to change the premium rates.

Health care costs. These include all costs of HMOs or other prepaid health care plans other than general and administrative, selling, maintenance, marketing, or interest.

Health maintenance organization (HMO). A generic set of medical care organizations organized to deliver and finance health care services. An HMO provides comprehensive health care services to enrolled members for fixed, prepaid fees (**premiums**).

Incurred but not reported costs (IBNR). Costs associated with health care services that have been incurred during the financial reporting period but that have not been reported to the HMO or other prepaid health care plan until after the financial reporting date.

Individual practice association (IPA). A partnership, association, corporation, or other legal entity organized to deliver or arrange for the delivery of health care services to enrolled members of an HMO or other prepaid health care plan. In return, the IPA receives either a capitation fee per member or a fee for service rendered.

Maintenance costs. Costs associated with maintaining enrollment records and processing premium collections and payments.

Medical group. An association of physicians and other licensed health care professionals, organized on a group basis to practice medicine.

Member. An individual who is enrolled as a subscriber or as an eligible dependent of a subscriber in an HMO or other prepaid health care plan.

Occurrence. The rendering of health care services covered by a contract with an HMO or other prepaid health care plan. Occurrences include admission to a hospital, a physician visit, emergency treatment, or a similar event.

Premium (or **subscriber fee**). The consideration paid to an HMO or other prepaid health care plan for providing contract coverage. Premiums or subscriber fees are typically set for individual, two-party, and family coverage.

Prepaid health care plan. A plan in which the provider is compensated in advance by the sponsoring organization. The sponsoring organization pays or compensates the provider based on either a fixed sum or a per enrollee amount. Prepaid health care plans include HMOs, PPOs, eye plans, dental plans, and similar plans. Under such plans, the financial risk of delivering the health care has transferred to the provider of services.

Provider. A person or entity that undertakes to provide health care services to an enrolled member of an HMO or other prepaid health care plan.

Reinsurance (or stop-loss insurance). A contract in which an insurance company agrees to indemnify an HMO or other prepaid health care plan for certain health care costs incurred by members. (The term reinsurance is used extensively in the HMO industry, but generally refers to insurance.)

Subscriber. The person who is responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other prepaid health care plan.

GENERAL BACKGROUND

5. A general description of a prepaid health care plan, specifically a health maintenance organization, follows. A more detailed description of HMOs is provided in the appendix.

6. An HMO is a formally organized health care system that combines delivery and financing functions. An HMO contracts to provide its enrolled members with comprehensive health care services for a fixed period (generally one year) in return for fixed monthly premiums.

7. Many HMOs are nonprofit entities, but there is a growing trend to establish for-profit entities. The Public Health Services Act and the regulations of the Department of Health and Human Services specify the features of and the reporting requirements for federally qualified HMOs, but HMOs are not required to be federally qualified. Most HMOs are also regulated by state agencies, typically the department of insurance or the department of corporations.

8. There are four basic models of HMOs. They differ in the type of relationship they have with physicians and enrolled members, as follows:

a. Staff model. Physicians are employees of an HMO. All premiums and other revenues accrue to the HMO, which compensates the physicians with salaries.

b. Group model. Physicians are organized as a partnership, professional corporation, or other association that contracts to provide services to members of one or more HMOs. The HMOs compensate the medical group at a negotiated per capita rate, and physicians are in turn compensated by the group.

c. Individual practice association. This is an entity that contracts with an HMO to provide identified health care services in return for

a fee (generally a predetermined capitation fee). The IPA in turn contracts with physicians who continue in their existing individual or group practices. The IPA may compensate the physicians on a per capita, flat retainer, or fee-for-service basis.

d. Network model. Physicians are organized in single-specialty or multispecialty group practices. An HMO contracts with various groups to provide identified health care services over the contract term. Unlike the other models, the network model is not recognized for purposes of federal qualification.

9. An HMO usually provides financial incentives to physicians to control health care costs. Physicians or health care providers compensated on a capitation basis have incentives to keep total costs below the fees received. Contracts may also provide for bonuses if use of hospital and outpatient services is lower than expected. In the IPA model, a physician usually receives a percentage of a fee; the remaining amount is held by the IPA in a risk pool for later distribution based on cost experience.

10. An HMO's contractual arrangements with physicians, groups, IPAs, or hospitals determine which entity bears the risk for adverse experience. An HMO may fix its costs and thus limit its risk by compensating health care providers on a capitation basis, rather than on a fee-for-service basis. Likewise, an IPA may limit its risk by contracting with physicians or hospitals on a capitation basis. In the staff and group models, costs of physician and outpatient services are relatively fixed because the physicians and support personnel are salaried employees. Accordingly, in many situations, substantial portions of an HMO's total costs are relatively fixed and do not vary with the amount of services provided. Incremental costs mostly consist of services purchased on a fee-for-service basis, primarily those specialized services that must be purchased from outside providers.

11. Premium rates typically are set by HMOs for a contract period of one year and are designed to cover the anticipated total cost of services to be rendered to the group of members during that period. Premiums are often community-rated; that is, one premium rate schedule is established for all members in a particular geographical area.

12. Under a community-rating method, each member is charged the same premium for the same set of benefits. The intent of this method of setting premium rates is to distribute health care costs equally over the community of subscribers rather than charge the unhealthy more than the healthy. The premium revenue is expected to cover the health care costs of the entire membership.

13. Alternatively, under an experience-rating method, premiums are based on the actual or anticipated health care costs of each contract. Those contracts that incur higher health care costs in proportion to other contracts would pay higher premiums.

14. A fundamental distinction between community rating and experience rating relates to the nature and size of the population that is used as the base for rate setting. In a community-rated HMO, the community is generally understood

to mean the HMO's entire membership. Alternatively, under experience rating, each contract constitutes a separate population base.

15. Premiums are generally required to be paid monthly in advance, and members can cancel contracts at the end of any month. An HMO generally cannot cancel contracts or increase premium rates during the contract period.

16. Premium revenue generally is recognized as revenue in the month that members are entitled to health care services. Premiums collected in advance generally are recorded as deferred revenue.

17. An HMO undertakes to provide health care services during the contract period. HMOs generally do not exclude preexisting conditions and generally do not provide health care services if the premiums are not paid, even if the injury or illness occurred during the contract period.

18. In certain circumstances, such as contractual obligation, state regulation, or management policy, an HMO may continue providing service to a member who was hospitalized as of the end of the contract period until the member is discharged from the hospital or until medical care ceases. The HMO also may provide for an extension of coverage for specific items such as pregnancy.

ACCOUNTING FOR HEALTH CARE COSTS

Discussion

19. The primary issue is whether a prepaid health care plan should recognize as an expense (a) the cost of health care services when those services are rendered, or (b) as of the date of initial service, the cost of future health care services expected to be provided to members for illness or conditions requiring continuing medical treatment.

Present Practices

20. There is considerable diversity among prepaid health care plans in accounting for health care costs:

- Some plans account for health care costs on the cash basis.
- Some plans accrue health care costs as the costs are reported to the plan.
- Some plans accrue health care costs as the services are rendered, including an estimate of costs incurred but not yet reported to the plan.
- Some plans accrue the estimated future cost to complete the hospital services to be provided to hospitalized members if the hospitals are compensated on a fee-for-service basis.

In addition, some have proposed that prepaid health care plans should accrue, as of the date of initial service, the estimated cost of services to be

provided over the remainder of the contract term or in all future periods to those members who will require continuing treatment.

Views on the Issue

21. Cash Basis and As-Reported Basis. Generally accepted accounting principles require accrual accounting. Thus, the recognition of health care costs as expenses only as they are paid or as they are reported to the plan does not conform with generally accepted accounting principles.

22. Accrual as Services Are Rendered. Those who favor the accrual of health care costs when health care services are rendered during the period, including an estimate of costs incurred as of the financial statement date but not yet reported to a plan, believe that this method recognizes a plan's expenses in proportion to the services provided—a desirable treatment. Supporters of this method believe that the service a plan undertakes is to provide health care to members for a specified period. A plan's premium rates are established to produce sufficient revenues over a contract period to cover the costs of providing health care services, including amounts contingently payable to hospitals, physicians, or other health care providers under risk retention, bonus, or similar programs. Since premium revenues are recognized over the premium period, supporters of this approach argue that recognition of expenses over that period as services are provided results in the appropriate matching of revenues and expenses. They also believe that because a plan does not have an obligation to provide services after the premium period, it should not accrue a liability for future services.

23. Some who contend that a prepaid health care plan should accrue costs as health care services are rendered believe that, when a member is admitted to a hospital, the services are rendered and the costs of the hospitalization should be accrued. They argue that, under many contracts, a plan will continue to provide services to a hospitalized member until the member is discharged, regardless of whether the contract expires or premiums are not paid after the member is admitted to the hospital. They believe, therefore, that the expense is incurred when a member is hospitalized because the plan cannot later avoid the costs associated with that hospitalization.

24. Accrual as of Date of Initial Service. Some believe that by enrolling a member, a prepaid health care plan assumes an obligation to provide health care services. They argue that under the requirements of Financial Accounting Standards Board (FASB) Statement No. 5, Accounting for Contingencies, the obligation becomes a liability as of the date a member is determined to have a particular illness or condition that will require the member to obtain future health care services (that is, the date of initial service). Paragraph 35 of FASB Statement of Concepts No. 6, Elements of Financial Statements, defines liabilities as "probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or provide services to other entities in the future as a result of past transactions or events." They believe that if a member develops a health problem requiring significant future health care, the member would probably pay the required premiums or maintain coverage because the cost of premiums would be far less than the cost of the health care services that would be required. Thus, they believe that, as a result of the member's participation in a plan, it is

likely that the plan would provide future services, and they believe that this meets the definition of a liability.

25. Supporters of this approach believe that it is consistent with current methods used to account for accident and health insurance by insurance enterprises. An insurance enterprise records a liability for the estimated future costs associated with a claim when the event that leads to the claim occurs. They believe that participation in a prepaid health care plan is an alternative to accident and health insurance, that prepaid health care plans have obligations similar to those of insurance enterprises, and that, therefore, a prepaid health care plan should accrue costs in the same manner as an insurance enterprise.

26. Some supporters of this approach contend that the costs that should be accrued as of the date of initial services relate to the services to be provided during the remainder of the contract period. They view the prepaid health care plan's contract with its members as being analogous to a short-duration insurance contract, and claim that the plan is obligated for the contract term. Consequently, it is reasonable to assume that plan members will continue to pay premiums during the contract term. They believe that costs should not be accrued for services beyond the contract term because the plan has the ability to change the premium rates and other contract provisions when the contract is renewed, or the plan can even decline to renew the contract. Thus, they maintain there is no past transaction or event that gives rise to an obligation to provide services beyond the contract term.

27. Others believe that the costs that should be accrued as of the date of initial service relate to all future services expected to be provided to the member. They view a prepaid health care plan's agreement with its members as being analogous to a long-duration insurance contract. Supporters of this position argue that it is reasonable to assume that members with significant health problems will continue to renew their contracts with the plan and thus it is probable that the plan will incur the costs of providing services even after the contract term.

28. Opponents of the methods discussed in paragraphs 24 through 27 believe that a prepaid health care plan does not have a liability for future services. They contend that the past transaction or event that results in a liability for the plan is the payment of premiums to the plan and that this is recorded as a liability for unearned premiums. As the premiums are earned, the related expense is recorded as the services are rendered. The opponents believe that a liability should not be recorded on the basis of an assumption that future premiums will be paid, because such an obligation relates to events of transactions in future periods.

29. Those opponents also believe that insurance accounting should not necessarily be used by prepaid health care plans. An insurance policy insures the individual for certain future medical costs incurred as a result of an accident or event that occurs during the policy period. As such, an insurance enterprise perhaps should recognize those future costs when the event occurs. A prepaid health care plan, however, undertakes to provide health care services for a particular period without regard to the timing of the accident or event that leads to the service.

30. Those opponents believe, furthermore, that those methods could result in a mismatching of revenues and expenses because they would recognize a relatively greater amount of expense in the earlier part of the contract period, whereas the methods discussed in paragraphs 22 and 23 would result in a more level recognition of expense over the period. The methods described in paragraphs 24 through 27 would also require a significantly greater degree of estimation, which could adversely affect the cost of preparing financial statements and the usefulness of the information. The method in paragraph 27 might also require consideration of factors such as estimated future premiums and the time value of money, which would add a greater degree of subjectivity to the financial statements.

31. Nature of Costs to Be Accrued. Some who believe that a prepaid health care plan should accrue estimated costs related to future services believe that the costs to be accrued should be only the incremental costs that will be incurred as a result of the health care services to be provided. Costs such as physicians' salaries and capitation fees or other costs related to plan-owned hospitals or other inpatient facilities that will not increase as a result of the amount of services to be provided should not be accrued. They believe that the accrual should relate to identifiable incremental costs of providing health care services and not to fixed period costs. Others believe the costs that should be accrued include all costs incurred in providing the services because those costs are directly related to the plan's obligation. They would accrue an allocable portion of the nonincremental costs.

Conclusions

32. Prepaid health care plans should accrue health care costs as services are rendered, including estimates of costs incurred but not yet reported to the plan. When it is determined that a contract with a sponsoring employer or other group will be terminated, the estimated costs that will be incurred after the contract period, net of any related anticipated revenues, should be accrued.

33. Amounts contingently payable to hospitals, physicians, or other health care providers under risk retention, bonus, or similar programs should be accrued during the contract period based on experience to date.

34. The financial statements of a plan and its associated entities should disclose the basis for accruing health care costs as well as significant business and contractual arrangements that the plan has entered into with hospitals, physicians, and other health care providers.

LOSS RECOGNITION

Discussion

35. A prepaid health care plan enters into contracts at a fixed monthly premium to provide members with specified health care services for a specified period. Associated entities, such as medical groups and IPAs, may enter into similar contracts with a prepaid health care plan in which they agree to provide members with identified health care services for a specified period in

return for a fixed capitation fee. Such contracts can be terminated only by the action or inaction of the member, such as failure to make premium payments. The premium revenue is expected to cover health care costs and other costs over the term of the contract. Only in unusual circumstances would a plan be able to increase premiums on contracts in force to cover expected losses. A plan may be able to control or reduce future health care delivery costs to avoid anticipated losses, but the ability to avoid losses under the contract may be difficult to measure or demonstrate beyond a reasonable doubt.

36. Expected losses on contracts are currently recognized in other industries—for example, in construction contracting and in the insurance industry—in which premium deficiencies are required to be recognized when anticipated claims and other costs are expected to exceed unearned premiums. FASB Statement No. 5, paragraph 96, states that

> this Statement does not prohibit (and, in fact, requires) accrual of a net loss (that is, a loss in excess of deferred premiums) that probably will be incurred on insurance policies that are in force, provided that the loss can be reasonably estimated, just as accrual of net losses on long-term construction-type contracts is required.

Present accounting literature does not specifically address the question of whether prepaid health care plans and related entities should accrue anticipated losses on health care contracts in force.

Present Practice

37. Currently, prepaid health care plans do not accrue losses when anticipated costs are expected to exceed anticipated revenues during the unexpired terms of the existing contracts.

Views on the Issue

38. Some believe that prepaid health care plans should not accrue for anticipated losses on contracts. They maintain that health care costs incurred in subsequent periods are not costs of the current period because the events giving rise to anticipated health care costs (that is, the rendering of service) have not occurred. They believe that plans are obligated, in most cases, to provide services only as long as premiums are paid. They believe that providing for anticipated losses involves the assumption that the contract will continue and that future premiums will be paid, but those events relate to a future period. Because plan premiums generally are collected monthly to cover the cost of treatment during that month, prepaid health care plans do not record a significant liability for unearned premiums as do insurance companies, and the premium deficiency concept of insurance accounting does not apply to prepaid health care plans. Accordingly, because there are no significant unearned premiums and the member has no contractual obligation to pay premiums, premium deficiencies should not be accrued.

39. Others believe that prepaid health care plans should recognize losses when the anticipated future contract premiums are less than estimated future health care costs and maintenance expenses. They note that the basic agreement between a plan and the member fixes the premium rate for the entire

contract period, and the contract can be terminated only by the member. Consequently, the plan's ability to avoid suffering anticipated future losses is limited. They believe that the criteria for accruing a liability in accordance with FASB Statement No. 5 have been met when it is probable that projected health care costs and maintenance expenses will exceed anticipated premium revenue to be received over the remaining terms of existing contracts.

40. Some who argue that contract losses should be recognized believe that the losses should be determined on an aggregate basis for all contracts in force at the end of the period. They maintain that the losses should not be determined on a contract-by-contract basis because the services provided under the contracts are similar and losses on individual contracts are likely to be recovered by profits on other contracts.

41. Others believe that, though many prepaid health care plans may group their contracts on an aggregate basis, to determine the existence of a loss, contracts should be grouped on the basis of common characteristics such as geographical location or family or employer composition, used to establish community premium rates (community rating). Federally qualified prepaid health care plans are required at present to use community rating, and its use may also be required by local statutes.

42. Some believe that under a community-rating method, if a plan anticipates a loss on a specific contract within a group, such a loss would not be recognized because unrealized profits on other contracts within the group would cover anticipated losses.

43. They believe that in a community-rated plan that executes one or more contracts with a single employer in several different geographical areas, different premium rates are charged in each of those areas. In such circumstances, the plan aggregates losses within each respective community rather than combining the experience of the employer as a whole.

44. Some prepaid health care plans determine losses on a contract-by-contract basis by using an experience-rating method for individual contracts. Under this method, premiums are based on the actual or anticipated health care costs of each contract. Contracts that incur higher health care costs in proportion to other contracts would pay higher premiums.

Conclusions

45. When it is probable that expected future health care costs and maintenance expenses under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries on those contracts, a loss should be recognized. Contracts should be grouped in a way consistent with the prepaid health care plan's manner of establishing premium rates—for example, by community-rating practices, by geographical area, or by statutory requirements to determine if an anticipated loss exists.

ACCOUNTING FOR REINSURANCE

Discussion

46. Reinsurance is a method by which prepaid health care plans transfer a portion of their risks to another company. Typically, a plan contracts with an insurance company for excess reinsurance. That is, a plan will generally reinsure all, or a portion, of health care costs incurred on behalf of a member that exceed a stated amount during the contract period. The reinsurance company agrees to reimburse a plan for all, or for a portion, of the health care costs in excess of the stated amount. Occasionally, a plan may purchase excess loss or stop-loss reinsurance, which limits the aggregate amount of its loss during a specific period to a stated amount. The reinsurance company agrees to reimburse a plan for all health care costs incurred during that period in excess of the stated amount.

47. Present accounting literature does not address accounting for reinsurance transactions by prepaid health care plans. In FASB Statement No. 60, Accounting and Reporting by Insurance Enterprises, paragraphs 38 through 40 and 60f describe the accounting and disclosure requirements for reinsurance transactions by insurance enterprises.

Present Practice

48. In the income statement, some plans record reinsurance premiums paid as an operating expense, whereas others record them as a reduction of gross premium revenue. Some plans account for amounts recovered from reinsurers as additional revenue, and others reduce health care costs by the amount of reinsurance recoveries received or receivable.

49. In the balance sheet, some plans record amounts recoverable from reinsurers for paid losses (costs) as reductions of the related liability account. Others record all amounts recoverable from reinsurers as assets, subject to appropriate valuation allowances.

Views on the Issue

50. Prepaid health care plans generally view reinsurance premiums paid as an operating expense and a normal and recurring business transaction incurred to provide protection from excessive loss. In turn, they view reinsurance recoveries as additional revenue. Such views are consistent with uniform reporting practices adopted by plan regulators. Some plans consider the reinsurer to be providing a portion of the member's coverage for a premium. Consequently, they view a portion of the gross premium collected as due to the reinsurer and, accordingly, as a deduction to arrive at net premium revenue. Because the reinsurer is considered to have assumed a portion of the risk and to be responsible for that portion of the loss, health care costs are reduced by the amount recovered or recoverable from the reinsurer.

51. Some believe that amounts recoverable from reinsurers for unpaid losses should be applied to reduce the related liability, because they believe that reinsurance is inextricably linked to the basic contract. For example, if the amount of health care services provided exceeds the amount a plan is willing

to undertake, that plan can issue a contract for either a portion of the coverage or for the total coverage and then reinsure the coverage in excess of the amount it will retain. In either case, the net financial statement result is the same.

52. Others, who believe that all amounts recoverable from reinsurers should be classified as assets, base their views on the generally accepted accounting principle that receivables and payables to unrelated parties should not be offset.

Conclusions

53. Reinsurance premiums should be reported as a health care cost. Reinsurance recoveries on health care costs should be reported as revenue. Receivables representing amounts recoverable from reinsurers that relate to health care costs should be classified as assets, reduced by appropriate valuation allowances.

54. Prepaid health care plans should disclose (a) the nature of significant reinsurance activities, (b) the amount of reinsurance premiums reported as health care costs, (c) the amount of reinsurance recoveries reported as revenue, and (d) the estimated amounts recoverable from reinsurers that are related to health care costs.

ACCOUNTING FOR ACQUISITION COSTS

Discussion

55. To associate the costs of acquiring business with the premium revenue generated, insurance companies defer certain acquisition costs and amortize them as the related revenues are earned. The issue of whether prepaid health care plans should follow a similar accounting policy for costs incurred in connection with writing contracts and obtaining premiums is not addressed in current accounting literature.

Present Practice

56. Many prepaid health care plans incur costs that vary with and are primarily related to the acquisition of subscriber contracts and member enrollment thereunder. These costs, sometimes referred to as marketing costs, consist mainly of commissions paid to agents or brokers and incentive compensation based on contracts. Commissions and incentive compensation may be paid when the contract is written, at a later date, or over the term of the contract as premiums are received. Some plans incur costs directly related to the acquisition of a specific contract, such as the costs of specialized brochures, marketing, and advertising. Plans also incur costs that are related to the acquisition of business but that do not vary with the volume of business acquired. These costs include salaries of the marketing director and staff, general marketing brochures, general advertising, and promotion expenses. Currently, most plans account for all acquisition costs as period costs, whether they vary with or are primarily related to the acquisition of business. Accordingly, those costs are expensed as incurred.

Views on the Issue

57. Some favor continuing the present practice of expensing all acquisition costs as incurred. They believe that the costs incurred by a plan may not provide a discernible future benefit and, therefore, should not be capitalized. They also believe that the costs of acquiring subscriber contracts generally are immaterial and that the period over which to amortize such costs is relatively short and would have an immaterial effect on the financial statements. Further, they believe that the cost that would be incurred to identify acquisition costs for deferral on a group or specific contract basis would outweigh any benefits to be derived from deferring such costs.

58. Others who support expensing acquisition costs cite regulatory accounting practices for prepaid health care plans reporting to certain state departments of insurance. Some state departments require commissions and other marketing expenses in connection with acquiring business to be charged to expense as incurred. Those supporters also believe that other industries expense marketing costs as incurred and that capitalizing such costs might create a different accounting treatment under similar circumstances.

59. Others favor deferring acquisition costs, such as commissions, incentive compensation based on production, and incremental marketing costs directly related to a successful campaign to specific groups. Such costs would be charged to expense over the contract term in proportion to the premium revenue recognized. They believe that only those costs that vary with and are primarily related to the acquisition of business should be deferred. They cite the principle in paragraph 157 of APB Statement No. 4, Basic Concepts and Accounting Principles Underlying Financial Statements of Business Enterprises, which states that "some costs are recognized as expenses on the basis of a presumed direct association with specific revenue.... Recognizing them as expenses accompanies recognition of the revenues."

Conclusion

60. Although there is theoretical support for deferring certain acquisition costs, acquisition costs of prepaid health care plans should be expensed as incurred because of industry and regulatory accounting practices.

EFFECTIVE DATE AND TRANSITION

61. This statement is effective for fiscal years beginning on or after December 15, 1986, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively. In the year during which this statement is first applied, the financial statements should disclose the nature of any restatement and its effect on income before extraordinary items, net income, and related per share amounts for each year restated.

APPENDIX

DESCRIPTION OF HMOs

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OVERVIEW

A-1. A health maintenance organization is a formally organized system of health care that combines the functions of delivery and financing. The HMO contracts with members to provide comprehensive health care services in return for a fixed monthly premium for a fixed period, generally one year.

A-2. HMOs are categorized by federal regulation as one of three models: staff, group, or individual practice associations. Various permutations are also possible. Regardless of the model, the HMO itself is the umbrella organization that administers the operation of the plan, monitors the use of services, and interacts with the medical staff and other personnel as well as with the enrolled members. The service area of the HMO is a geographical one in which members are able to obtain services from the organized health care delivery system.

A-3. Many HMOs are nonprofit entities. A variety of organizations, with and without federal financial assistance, have sponsored the development of HMOs: consumer groups, industry, labor unions, medical schools, insurance carriers, Blue Cross/Blue Shield service plans, medical groups, partnerships and professional corporations, independent community hospitals, for-profit and nonprofit hospital chains, cities, medical societies, neighborhood health centers, and business coalitions.

A-4. HMOs exist in a regulated environment. They are not required to be federally qualified (that is, an entity that has been found by the Secretary of the Department of Health and Human Services to meet the applicable requirements of Title XIII of the Public Health Service Act and its regulations), but there are two significant advantages to qualification:

1. Federally qualified HMOs benefit from the legislative mandate of "mandatory dual choice." This provision requires most employers in the HMO's service area to include the option of an IPA and a group model HMO, if available, in any of their health care benefit plans.

2. Many employers believe that federal qualification is a prerequisite for including the HMO in their health care benefit plans. Federally qualified HMOs must comply with complex federal reporting requirements. Most HMOs are under the control of state agencies, typically the department of insurance or the department of corporations. These departments impose certain operating requirements as a condition for continued licensure, qualification, or contractual relationships.

A-5. Enrollment in HMOs is recruited from the following specific groups as defined by principal sources of payment for medical care: large group employers, public employers, Medicaid and Medicare beneficiaries, small group aggregates, and individuals.

A-6. The services that HMOs offer vary. However, to be a federally qualified HMO, the entity must include the basic health services of the HMO Act, which must be provided to members without restrictions on time and cost, except for certain prescribed limitations (for example, maximum visits for mental health and copayments). The basic health services include (1) diagnostic and therapeutic services, (2) inpatient hospital services, (3) short-term rehabilitation, (4) emergency health care services, (5) short-term, outpatient evaluative mental health services, (6) services for abuse of or addiction to alcohol or drugs, (7) diagnostic laboratory and diagnostic and therapeutic radiological services, (8) home health services, and (9) preventive health services, such as prescription drugs, dental care, and vision care.

A-7. A member may have health care coverage under more than one health care plan or insurer. In those cases, responsibility for the payment of costs is allocated among the parties, based on provisions of law, regulation, or contract in a process called coordination of benefits (COB).

A-8. The cost of services is met by the prepaid monthly premium, which is designed to cover the cost of health care services, the cost of acquiring and enrolling members, and general and administrative expenses, as well as to provide a margin for adverse experience or profit. To remain competitive, some HMOs establish member copayments that supplement the premium for the basic health care services. A typical copayment is a two- to five-dollar charge for an office visit to a physician.

HMO MODELS

A-9. There are four basic HMO models. They are differentiated by the type of relationship that has been established between the physicians who deliver the services to members and the legal corporate entity, the HMO.

A-10. Staff Model. Physicians are organized as employees who devote their practices to the HMO. All revenues (premiums and any fee for service revenues) accrue to the HMO, and physicians are compensated by an arrangement other than fee-for-service, such as salary or retainer. The physicians generally practice as a group in a centralized facility and share common support personnel, medical records, and equipment. This model is also referred to as a "closed panel," because enrollees may select only from among these physicians to receive contracted physician-service benefits.

A-11. Group Model. Physicians and other licensed health care professionals are organized as a partnership, a professional corporation, or another association that executes an agreement or contract with one or more HMOs. The physicians and health professionals are not salaried employees or "staff" of the HMO, but this model is still considered a "closed panel." As their principal professional activity, they engage in coordinated practice; as a group, they devote a significant amount of their aggregate activity to the delivery of health services to HMO members. Like the staff model, members of the medical group share records, equipment, and professional, technical, and administrative staff. The HMO compensates the medical group at a negotiated per capita rate, which is then distributed to the individual physician group members according to a prearranged schedule.

A-12. Individual Practice Association Model. An IPA is a partnership, association, corporation, or other legal entity that delivers, or arranges for the delivery of, health care services in accordance with a contract with an HMO. The IPA accepts a fee (generally a predetermined capitation fee) and a corresponding obligation to provide identified health care services over the contract term. To provide the services, the IPA enters into service and compensation arrangements with health care professionals. This model differs from the previous two in that physicians continue in individual or group practice and maintain their existing offices. Many IPAs originally were sponsored by local medical societies as "foundations for medical care," and all or most of the physicians in an area usually were invited to participate. Thus, the IPA became associated with the concept of an "open panel" practice. Membership in an IPA does not limit a physician's practice to treatment of HMO enrollees.

A-13. The HMO may compensate the IPA at a negotiated per capita rate for enrolled members. Likewise, the IPA's compensation arrangement with member physicians may be at a negotiated rate per capita, on a flat retainer fee, or on a fee-for-service basis. To reconcile fee-for-service compensation to physicians with the fixed prepaid revenue the IPA receives from the HMO, the physician often agrees to a discounted fee schedule or an acceptance of a degree of financial risk. That is, the physician will agree to accept a percentage of his or her regular fee or a discounted fee with the balance held in reserve. At year end, if the use of the health care services has been within the projected limits, the physicians may receive the balance of their claims after provision for contingencies. If premiums are inadequate, the physician may agree to accept a pro rata decrease in fees and may even be liable for inappropriate hospital costs.

A-14. Network Model. As with the group model HMO, physicians and other licensed health care professionals are organized as partnerships, professional corporations, or other associations for the group practice of medicine. These group practices may be multispecialty or single-specialty practices. The HMO contracts with various group practices to provide identified health care services over the contract term. As compensation for providing these services, the groups receive a fixed capitation fee per member per month, regardless of the number of visits the members make to the groups. This income is then distributed to the individual physician-group members according to a prearranged schedule. Unlike other models, a network model is not a recognized category for purposes of federal qualification. Network models applying for federal qualification have generally been categorized as IPAs when qualified. However, network model characteristics are generally similar to the group model characteristics.

COST AND USE CONTROL

A-15. To control health care costs and the use of services, an HMO generally assigns each member, or allows a member to choose, a primary care physician. This physician typically authorizes all services, including hospitalization and referral to member specialists and nonmember physicians. Under a capitation system, the physician has an incentive to maintain costs at or below the capitation fee received. Most group models are on a capitation basis. Additionally, financial incentives are usually provided to physicians to reduce

health care costs. Contracts may provide for a sharing of any savings realized from lower-than-expected use of hospital and outpatient services. In the IPA model, the physician usually receives a percentage of the agreed fee, with the remaining amount held by the IPA in a risk pool. If use of hospital and outpatient facilities for the year is as expected, the physicians receive the remaining amount; if it is lower than expected, they may share in a risk pool; and if it is higher than expected, they receive a lower percentage of their billed fee. The IPA may also share in a hospital risk pool, if any, and the physicians would share in any savings realized as a result of lower hospital use. An HMO may also control use through medical review boards, prehospitalization certification, or prereferral screening.

HOSPITALIZATION SERVICES

A-16. A few HMOs own and operate hospitals or other inpatient facilities. However, inpatient hospitalization, except for bona fide emergency care services, is usually provided by hospitals that have contracted with the HMO. The relationship between hospitals and HMOs may be informal, with the hospital granting admitting privileges to a plan's physicians, or there may be a formal contract under which the hospital guarantees the availability of a predetermined number of beds, regardless of whether the beds are actually used. Several financial arrangements are possible. The HMO may pay the hospital a periodic amount, similar to a retainer, for a given number of beds. The HMO may make a prospective payment with or without retrospective adjustment at the end of the accounting period; or it may retrospectively reimburse the hospital. In the last two cases, the HMO pays according to a fee-for-service arrangement, which may be either full or discounted costs and charges. HMOs may also compensate hospitals based on costs incurred or on a specific fee basis.

RISK EVALUATION

A-17. An HMO's contractual arrangements with IPAs, groups, and hospitals determine which entity bears the risk for adverse experience if actual health care costs exceed the premium or capitation fee received and the extent of that risk. For example, the HMO may continue to bear the risk of adverse experience for hospitalization and related inpatient charges, but it may shift the risk for physician and outpatient services to the group or IPA by a capitation-compensation arrangement. Drug costs may be retained by the HMO or may be capitated to the group or IPA. In the latter situation, the extent of risk borne by the group or IPA depends primarily on the physician compensation arrangement. Compensation on a fixed-salary basis, provided enrollment is sufficient to cover those salaries, generally limits risk to the amount of outside costs incurred for specialists who are not members of the group. Likewise, compensation of IPA physicians on a capitation basis limits the IPA's risk. If the IPA or group provides for fee-for-service or incentive compensation, respectively, its risk exposure is greater because its claims may exceed capitation fees, and the IPA may be unable to lower the fees paid to physicians. Additionally, the IPA may not be able to retain physicians since they have the option of withdrawing from the IPA.

A-18. A few HMOs function primarily as marketing and facultative agencies and bear no risk for adverse experience. This type of HMO contracts with one or more IPAs and hospitals on a capitation basis, retaining a portion of the fee to cover marketing and administrative costs. In this situation, the adverse experience risk is borne by the IPAs and hospitals. This shifting of risk may be of short-term benefit to the HMO, since the hospitals, groups, or IPAs with adverse experience are likely to demand higher capitation fees or refuse to renew the contract.

A-19. By contractual agreement, the HMO may shift the burden of providing and paying for services to the medical group or IPA. In this situation, the HMO pays the medical group or IPA a capitation fee to provide a predetermined range of physician and other outpatient services. In the group and staff model HMOs, physician and other outpatient services are period expenses and are relatively fixed, because the physicians and medical-support personnel are salaried employees. Although the number of employees will vary with the level of enrollment, this variance is a step increment.

A-20. In the group or staff model HMO, incremental costs consist primarily of nonemployee specialized services that must be purchased (for example, the services of a specialist in open heart surgery). In an IPA model, physician service costs will be fixed for the HMO if the IPA is compensated on a capitation basis. In this situation, incremental costs would be incurred only if services must be purchased from nonmember providers. Likewise, if an HMO owns its own hospital or compensates its member hospital on a capitation or other fixed basis, incremental costs are generally limited to costs incurred at nonmember facilities, such as out-of-area or emergency services. If member hospitals, IPAs, groups, or individual physicians are compensated on a fee-for-service basis, each service may be viewed as an incremental cost.

COMPARISON OF HMOs AND INSURANCE COMPANIES

A-21. Both HMOs and insurance companies provide coverage for health care services. The fundamental difference between HMOs and insurance companies is that HMOs also undertake to provide, or arrange for the provision of, the covered health care services. In providing such services, the HMO exercises some control over the use of these services and frequently must approve coverage of certain services before they are provided. The insurance company provides an indemnity and does not have the ability to approve services or, therefore, to refuse a covered claim before the services are provided.

A-22. HMOs and insurance companies consider the following similar factors in determining the premium charged for coverage.

A-23. Cost Assumption. Premium rates are established by HMOs and insurance companies, for either a group or an individual policy, by projecting the anticipated costs of providing the health care services, expenses, and a margin for adverse experience or profit. The projections include, in addition to anticipated price changes, estimates of hospital days, physician visits, outpatient services, maternity, and participant termination. Also included are estimates for care extended beyond the contract or policy period.

A-24. Risk Assumption. HMOs and insurance companies frequently differ in their risk-rating approach to setting premiums. Insurance companies aggregate claims experience and estimate experience ratings for each insured group. Federally qualified HMOs are required to set community rates by geographical area or by actuarial classes, whereas nonqualified HMOs may use individual-contract group ratings. As a result, federally qualified HMOs and HMOs that do not use group rates run a greater risk of adverse experience than do insurance companies.

A-25. Coverage Period and Payment Mode. Premiums are typically set by HMOs and insurance companies for a contract period of one year and are designed to cover the anticipated costs for that period. Some believe that HMOs differ from insurance companies in that the premiums cover the anticipated costs on a monthly basis. This is a somewhat artificial distinction because health care services show seasonal variations, and premiums are designed to cover health care costs over the contract term. Both insurance companies and HMOs experience seasonal variation in claims throughout the contract period.

A-26. HMOs and insurance companies recognize premium revenues in essentially the same manner. Premiums generally are paid on a monthly basis in advance. If the participant cancels coverage, the cancellation generally takes effect as of the last day of the month to which the last paid premium applies.

A-27. A policyholder or member may cancel an insurance policy or HMO contract at any time. Generally, cancellation may be made only by the insured, not by the HMO or insurance company. The insurance company or HMO is committed to provide coverage during the contract period (so long as the premiums are paid) and may not terminate coverage, even if they have had or will have adverse experience.

A-28. An insurance company is liable for coverage of an insured incident that occurs while the policy is in force, even though the costs related to the incident are incurred after the policy is terminated. For an insurance company, extended coverage would include the following:

- Hospitalization and physician services directly related to the incident
- Extended benefit provisions, typically included in major medical policies, for a limited duration (such as to the end of the calendar year in which the policy terminates, plus one year), and may include maternity extensions (although many insurance companies are deleting this feature)
- Total disability, for which the duration of coverage is usually limited, and care incident to a specific occurrence

A-29. An HMO has an obligation to provide health care services during the contract period, provided the premiums are paid. Generally, the HMO does not have an obligation to provide services after a member has stopped premium payments, even though the accident or condition for which the member obtains health care occurred during the contract period. However, an obligation may extend beyond the contract or premium-paying period, depending on the specific contract terms, federal or state regulation or policy, or the HMO's management

policy or common practice. Certain contracts provide for extension of coverage for specific items such as pregnancy. The HMO may have an obligation for extension of benefits to hospitalized participants, including not only hospital charges and related inpatient services but also physician and referral fees through the date of discharge. The HMO, however, does not have an obligation for extended care beyond the period of hospitalization.

A-30. Under a group contract with an insurance company, it is likely that the employer, depending on its disability policy, will continue to pay premiums while the employee is disabled. Similarly, it is also reasonable to assume that an individual HMO member requiring continued health care will continue to pay premiums because the premium cost would be far less than the related health care costs. A member may not continue to pay premiums as a result of inability, ignorance, or incapacitation, but many believe that the HMO has an obligation to continue to provide health care services to hospitalized members, and state policy or regulation may require such continued services.